

Alternative Housing and Incentive Program Manual

VDH TB PROGRAM

Alternative Housing and Incentive Program Requirements

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Introduction

The Alternative Housing and Incentive Program (AHIP) is administered by VDH's Tuberculosis Program and is overseen by the AHIP Program Manager. See [Appendix A](#) for information on the role of the AHIP Program Manager. The purpose of AHIP is to protect the public by financially assisting clients who would be at risk for non-adherence to the TB treatment plan. If the client meets criteria for participation, they may receive assistance for temporary housing, food, drug copay, and other types of special assistance. AHIP provides relief during the infectious period and is considered the fund of last resort. Efforts to seek local health district resources for assistance are expected before a request to AHIP occurs.

AHIP approval is granted in one month increments. However, assistance is not guaranteed, and this should be clearly explained to the client. The program may not cover the entire amount requested. Subsequent requests will be considered on a case-by-case basis.

Health districts shall identify a Nurse Case Manager (NCM) or designee when requesting AHIP assistance. See [Appendix B](#) for information on the role of the NCM or designee.

The NCM or designee should not discuss specifics of the AHIP Program with the client at the beginning of treatment. Instead questions like the following should be asked.

- How many people live in the home and contribute toward rent/mortgage/food?
- How much is your rent/mortgage?
- Are there family members or friends who can help pay your bills while you are out of work?
- Have you thought of other resources for assistance?

Program Criteria

In order to qualify for AHIP assistance, clients must meet **ALL** of the following criteria:

1. Client is presumed to have TB disease based on positive bacteriology, including positive smears for acid-fast bacilli (AFB), positive Nucleic Acid Amplification (NAA) test, abnormal chest x-ray, and/or clinical symptoms consistent with active tuberculosis disease.
2. For housing assistance, the client must not be able to work due to an isolation order related to the TB diagnosis.
3. The diagnosis of confirmed or presumptive TB disease must be affirmed by a VDH clinician or a clinician under contract with VDH.
4. The VDH clinician will confirm that a uniform and consistent definition of presumptive or confirmed TB is being used and that appropriate treatment is initiated.
5. Supervision of medical management by VDH, when the client has a private physician, is expected to assure VDH standards for TB care are being followed.
6. The client agrees to directly observed therapy (DOT). **This is not negotiable.** A DOT agreement form must be signed by the client.
7. The client demonstrates financial need for assistance.

Procedure for Participation

1. Requests for AHIP participation begin when local health district (LHD) staff identify a client with a financial need and have determined the client meets AHIP criteria.
2. The Need for AHIP Form ([Appendix C](#)) will be filled out by the NCM or designee and faxed to the TB Program at 804-371-0248 to the attention of the AHIP Manager. **Note, faxing this form does NOT guarantee assistance will be provided.** The following information must be included in the request:
 - a. Explanation of what resources the LHD has explored locally for assistance
 - b. The criteria the client meets for participation
 - c. LHD information (address and to whose attention)
 - d. The type of assistance needed and amount requested
 - e. A short summary of the client history
 - f. NCM or designee information
3. The form will be reviewed upon receipt, and if clarification is needed, TB Program staff will contact the submitter. This process should be completed within 1-2 business days. (Expedited requests are permissible for hotel/motel approval. In these instances, please mark “urgent” on the completed Need for AHIP Form prior to faxing.)
4. If the request for AHIP funds is approved, the AHIP Program Manager will inform the NCM or designee within 2 business days of receipt of the fax to the TB Program.
5. Upon notification of approval for funds, the NCM or designee shall discuss the AHIP Program with the client. The client must agree to abide by the rules of the program.
6. The NCM shall then complete the AHIP Participant Agreement Form ([Appendix D](#)) and have the client sign the form.
7. The completed and signed form must then be faxed to the AHIP Program Manager at (804) 371-0248. The AHIP request will not be processed until the AHIP Participant Agreement Form is received.

Food

Assistance with the cost of food is based upon the client’s financial need. The maximum available per month is \$150. As with other AHIP assistance, this is not guaranteed. LHD staff should investigate other resources for procuring food (i.e. food banks) prior to requesting AHIP funds.

1. Eligibility for Food Assistance – clients must meet ONE of these criteria:
 - a. Be under public health isolation orders
 - b. Need groceries for nutritional supplement while recovering
 - c. Lost employment or income source as a result of illness
 - d. Able to pay for housing instead of food
 - e. Lack of access to any other food sources
2. When requesting food assistance, designate a NCM or designee to whom the check will be made payable and include this person on the faxed request. Upon receipt of a request for food assistance, a check will be written for a **maximum of \$150.00 per month**, in the name of the designated person. This check will be issued by the contract vendor within seven business days of the request. All funds designated for food are restricted to **food items only**. Receipts for these items should be signed and dated by the client, placed in an envelope with the copy of the food check, and filed in the client’s medical record.
3. Depending on the client’s situation, the NCM or designee will take the following action:
 - a. If the client is under public health isolation orders and has no one to shop for them, purchase

- the necessary grocery items and deliver them to the client so that s/he does not have to go out in public.
- b. If the client is non-infectious and ambulatory, purchase gift cards in various amounts from a local grocery store; make copies of each, and deliver them periodically throughout the month to the client. Have the client co-sign and date the copy of the gift card, indicating it was received, and file the receipt in the client record. The client should provide the grocery receipts for at least the amount of the certificate in order to qualify for further assistance.
 - c. Upon receiving a food check in the name of a designated NCM or designee, copy the check and have a manager sign to verify that it was received for the purpose of purchasing gift cards or groceries for the client. Someone should be designated to review receipts for accuracy and completeness and document the review date. Retain the original grocery or gift card receipt(s) and a copy of the client's receipt of acknowledgement in the client's record. For auditing purposes, these receipts must be made available upon request. The NCM or designee should address and document any inappropriate gift card use with the client. Misuse of AHIP food monies will result in denial of further requests for assistance.

Housing

Requests for housing assistance are evaluated on a case by case basis. Housing assistance may be provided in the form of funds to pay for a motel room or the client's current rent/mortgage.

1. Hotel

- a. Placement criteria: The client must be medically well enough and able to care for themselves in an unsupervised environment before approval can be given for placement in a motel setting and one of the following:
 - i. The client must currently be experiencing homelessness and be willing to accept placement in a facility that provides housing to AHIP participants.
 1. Experiencing homelessness means that the client lacks stable housing or housing that meets the minimum housing standards. This may include those individuals who sleep in different places on a nightly basis.
 - ii. The health department requests that the client be removed from a living situation that has already or could negatively impact TB treatment adherence.
 - iii. The health department requests that the client be removed from a household where young (in general less than 5 years of age, though this may change depending on specific circumstances), previously unexposed children reside, where roommates who are immune-compromised reside, or if the unit is a congregate setting.
- b. Requesting assistance – initiated by NCM or designee
 - i. Review eligibility criteria and call the main line at (804)864-7906 and ask for the AHIP Program Manager to discuss eligibility. Allow two business days for processing requests and making placement arrangements.
 - ii. Identify an appropriate place that meets the minimum housing standards. ([See Appendix E](#))
 - iii. Obtain the name, address, phone number, fax number, and contact name of the housing location. Negotiate a rate and remember that we do not pay for phone use, or safes. Make sure they will be able to send invoices to the TB Program for payment ([See Appendix E](#)).

- iv. Hotels/motels and rental/management companies will need to complete a [W-9](#) form. This **MUST** be submitted prior to payments being processed.
- v. The AHIP Program Manager will fax a copy of the authorization letter to the NCM or Designee and the motel vendor. The NCM or designee will immediately notify the TB Program of any errors or changes from what is contained in the letter.

2. Current Residence

a. Criteria for assistance

- i. The client is unable to work because of the diagnosis of presumptive or confirmed infectious TB disease and has been placed in respiratory isolation, thus making them financially incapable of continuing to pay for housing. If the client receives no other income and is not eligible for other financial assistance, the client may be eligible for this program.
- ii. The client's current housing must meet the standards required by the TB program to be eligible. ([See Appendix E](#) for housing standards)

b. Requesting Assistance – initiated by NCM or designee

- i. Determine the name of the appropriate recipient of the rent or mortgage payment and the month that the payment will cover. Obtain the mortgage account number or unit number. (Review the rental agreement, cancelled checks, or the mortgage document to verify the amount.) **Payments are not made to the client for housing under any circumstances.** The check is mailed to the NCM or designee in the LHD. The NCM or designee should make a copy of the check when it arrives in the mail. Have the client sign the copy to acknowledge receipt of the assistance and maintain this copy in the client's record. **Note: 7-14 business days are required to process checks for rental payments.**
- ii. If the client is part of a group that pays rent, a check can be sent to the NCM or designee, who can either give it to the group or obtain a money order for the client's portion of the rent. Follow local policies for documenting that all AHIP monies were used for the money order.

NOTE: If a check is received and the money is not used for any reason, the NCM or designee shall write "VOID" on the check and return it to:

**Virginia Department of Health
109 Governor St.
Room 332D
Richmond, VA 23219
Attn: TB Program-AHIP Program Manager**

Continued Assistance

Clients are not automatically eligible for continued support from AHIP. Extensions are dependent upon ongoing need and availability of funds. In order to continue receiving AHIP assistance, clients must meet **ALL** of the following criteria:

1. Clients must continue to show a financial need for assistance.
2. Clients must adhere to DOT as prescribed.
3. Clients must keep scheduled clinical appointments.
4. Clients must follow all of the conditions of isolation while infectious.
5. Clients must obey all rules and regulations of the housing facility, if applicable.

Gift Cards

The primary purpose of this incentive is to encourage compliance with treatment for TB infection. Other funds are available for presumptive or confirmed TB cases. Examples of clients who may benefit from a gift card incentive include but are not limited to:

- A child on treatment where a small gift to encourage or reward adherence could improve the child's TB outcome.
- A client who comes to the health district for DOT of 3HP for whom there is a risk of stopping treatment due to a financial hardship.
- Contacts of an infectious case of TB when contacts include a population of individuals known to be difficult to find or evaluate.

1. Security and Containment Requirements

- a. A designee must be identified who will be accountable for record keeping and storage. This individual may be the NCM or another responsible district employee. If the responsible party changes, the TB Program must be made aware.
- b. Gift cards must be kept in a locked safe or in a locked cabinet with limited personnel access.
 - i. It is advisable to include the Gift Card Log and the Client Gift Card Receipt form(s) with the gift cards since these forms contain protected health information.
- c. The health district must abide by the outlined procedures to assure continued eligibility.

2. Procedure for requesting cards

- a. Call a TB nurse consultant to discuss eligibility of client(s).
- b. If approved, contact the AHIP Program Manager at 804-864-7921, who will be your primary contact going forward, with the following information:
 - i. A request for the number of cards needed
 - ii. Accurate mailing address
 - iii. Information on security and containment
 - iv. Name of individual who will be responsible for accounting of cards
- c. The number of gift cards requested will be recorded on the Gift Card Log ([See Appendix E](#)). This will be sent to you via certified mail along with the gift cards and a Client Gift Card Receipt. All of these items will be in the same package.

- d. The Client Gift Card Receipt ([See Appendix G](#)) requires client information and their signature (Use one per card transaction, per client).
- e. When distributing cards to clients:
 - i. Record their name, the date given, gift card number(s) (found on the back of the card), and the amount of the gift card(s) on both the Client Gift Card Receipt and the Gift Card Log.
 - ii. The client and the person distributing the card must sign the Client Gift Card Receipt.
 - iii. Secure the Receipt and Log with the remaining gift cards in the designated location at the LHD.
- f. Once all of the gift cards have been distributed, the health district must either physically mail or fax the completed Gift Card Log and all Client Gift Card Receipts to the TB Program. This must be done prior to any additional gift cards being issued to the health district.

3. Form Explanation

- a. Gift Card Log – This log will be used to log and track card(s) being sent to the health district.
 - i. Complete the top part of this form upon receipt of the gift cards in the mail.
 - ii. The gift card numbers and monetary amounts will be prefilled. Verify the numbers prior to distributing cards.
 - iii. Upon distribution fill out each section of the log corresponding with the card(s) distributed.
 - iv. Return the log to the TB Program once all cards have been distributed.
- b. Client Gift Card Receipt – This form will be used when distributing gift card(s) to each individual client.
 - i. Make copies of the form. Contact the TB Program if you need a new copy.
 - ii. Once completed, a copy of this form should be kept in the client's folder.
 - iii. Submit the original form to the TB Program upon distribution completion.

Appendix A

Role of the AHIP Program Manager

There is an assigned staff person in the TB Program who coordinates the AHIP Program. This staff person is responsible for coordinating AHIP requests with the VDH contract vendor to expedite approved requests for AHIP assistance and ensure timely delivery of assistance checks and payments. The AHIP Program Manager will also provide guidance on other AHIP Program special requests such as insurance related drug copayments.

Contact Information:

TB Main Line:	804-864-7906 –ask for the AHIP Program Manager
Fax Number:	804-371-0248

Appendix B

Role of the Nurse Case Manager or Designee

The NCM or designee in the LHD is responsible for providing important oversight related to the AHIP Program. This is usually the primary nurse working with the client. However, these responsibilities can be delegated to a designee.

The NCM or designee:

1. Takes an active role in the process of discharge planning of presumptive and confirmed TB cases prior to their release from hospitals. This interaction is especially critical for infectious clients who may have recently initiated treatment.
2. Performs a needs assessment on the client and determines current housing status.
3. Identifies food banks, soup kitchens, and/or emergency food service organizations to meet the basic need for food.
4. Provides assistance in locating appropriate housing with relatives, assisted living facilities, adult homes, single room occupancies, or shelters.
5. If the client has no housing resources available, contacts the TB Program for participation in the AHIP Program.
6. If assistance is needed beyond the initial approval period, contacts the TB Program to request additional assistance.
7. Provides ongoing case management to the client, including DOT.
8. Keeps the TB Program informed of any problems and/or questions regarding the AHIP Program.
9. Assumes responsibility for proper documentation of receipt and expenditure of AHIP monies for audit purposes and maintains this information in the client's medical record. This information shall include:
 - a. Copies of any checks received and signed by a supervisor to verify that the check was appropriately cashed and used to purchase gift certificates or groceries for the client
 - b. Grocery receipts for purchased items
 - c. Each receipt shall be reviewed for appropriateness of purchases by a designated individual in each district within two weeks. Appropriate purchases include food items only. The reviewer shall initial and date the document upon review.

Appendix C

Need for AHIP Form

☐ Urgent request for assistance

PLEASE WRITE LEGIBLY OR TYPE

Complete as much information as possible. You will receive a response within 1-2 business days after review by the TB Program. If approval is needed immediately, please check the box above.

Client Name _____ Time period to be covered _____

LHD must explain what resources for assistance have been explored: _____

Criteria for Participation	Diagnosis of presumptive or confirmed TB	<input type="checkbox"/>
	Requires isolation (Required for housing assistance)	<input type="checkbox"/>
	VDH supervising or consulting on medical management	<input type="checkbox"/>
	Signed Directly Observed Therapy Agreement and compliant with DOT	<input type="checkbox"/>
	Client at risk for unstable or unsafe housing	<input type="checkbox"/>
	Demonstrates financial need	<input type="checkbox"/>

Health Department Information	To whose attention	
	Location	
	Address	
	City/State/Zip code	
	Phone Number	

Assistance Needed	Payable to: (Landlord, rental/mortgage company, NCM or designee)	Amount Requested	Amount Approved
Housing	<input type="checkbox"/> Rent <input type="checkbox"/> Hotel <input type="checkbox"/> Mortgage	\$	\$
Food		\$	\$
Special Assistance	Describe:	\$	\$

Client Summary

Nurse Case Manager or Designee _____ Date _____

Phone Number _____ District _____

For TB Program Use Only

Approver Name _____ Date _____

☐ Letter Sent to Health Brigade

☐ Client entered on spreadsheet

Appendix D

AHIP Participant Agreement Form

While participating in the AHIP Program, the client agrees to adhere to the following standards.

1. Be available to all healthcare workers according to an agreed upon DOT schedule
2. Refrain from using alcohol or illegal controlled substances
3. Abstain from being verbally or physically abusive to any healthcare worker
4. Submit sputa and other laboratory specimens, as requested
5. Attend scheduled clinic appointments

While receiving food assistance, the client also agrees to:

1. Spend funds on healthy food items only
2. Submit all food receipts to the Nurse Case Manager

While receiving motel housing assistance, the client also agrees to:

1. Not have roommates or personal visitors, unless authorized by the NCM or designee.
2. Keep the room clean
3. Abide by the rules and regulations of facility management
4. Refrain from making noise or any behavior that results in complaints to management
5. Refrain from using alcohol or illegal drugs while in AHIP housing

I understand the above expectations and understand that failure to follow them will revoke my participation in AHIP.

Client's Signature

Date

VDH Representative Signature

Date

Appendix E

AHIP Housing Standards

When AHIP participants are placed in alternative housing, the NCM or designee will identify a suitable facility. The NCM or designee talks with the facility manager to determine if a vacancy exists for the time period needed, determines if the facility is willing to send invoices to the TB Program for delayed payments by credit card or state check, and then notifies the AHIP Manager. If the minimum standards are met and the facility is approved, an authorization letter will be faxed to the facility indicating that VDH will be responsible for payment.

It is recommended that the housing facility be convenient for providing DOT and provides a safe environment for the client. The NCM or designee will determine room availability, negotiate a rate (usually weekly), and assure that the room meets the minimum housing and safety standards. The facility will NOT be supported by AHIP until the minimum standards have been met. **Motels must provide a completed [W-9](#) form to be placed on the state vendor list, if not currently listed. This is required before payment can be made to the facility.**

NCMs or designees are asked to assess the potential housing unit to assure that it is clean, free of obvious dangers or hazards, and that the unit itself does not pose a health risk. The following criteria shall be considered.

Infection control measures when infectious

1. No shared air between rooms. Window or individual room units for air conditioning and heat with venting to the outside are best.
2. Rooms must have doors that open to the outside with no shared corridor entrances.
3. Housekeeping services must be suspended. Sheets and towels may be delivered to the door.

Minimum housing standards

1. Hot and cold running water
2. Heat during the colder months
3. The door should lock, open, and close with ease
4. Refrigerator and microwave in the room
5. Private, attached bathroom

Minimum client responsibilities

1. No roommates or personal visitors, unless authorized by the NCM or designee
2. Keep the room clean
3. Abide by the rules and regulations of facility management
4. Refrain from making noise or any behavior that results in complaints to management
5. Refrain from using alcohol or illegal drugs while in AHIP housing

Other general health and safety standards

1. Fire exit from the building should be readily available and not blocked in any way
2. Free from rats or infestation by mice or other vermin
3. Free from heavy accumulation of garbage or debris inside and outside the unit
4. Adequate facilities for temporary storage of food wastes or other garbage

5. Interior and exterior stairs and hallways free from hazards to the occupant (loose, broken, or missing steps on stairways; insecure railings; inadequate lighting; etc.)
6. Interior of the housing unit is free from any other potential hazards not specifically mentioned
7. Housing unit should be free from abnormally high levels of air pollution from vehicular exhaust, sewer gas, fuel gas, dust, or other pollutants

Appendix F

Gift Card Log

Health District _____

Date Sent _____

Please verify that the gift cards received match the card numbers listed on this log. Once verified, sign and date prior to distributing any gift cards. When all gifts cards have been distributed, this log must be submitted to the TB Program by fax (804) 371-0248.

Contract Monitor

Case Manager/Designee Printed Name

Signature

Signature

Date Received _____

Card Number	Case Manager/Designee	Client Name	Date Given	Signed Client Gift Card Receipt	Gift Card Amount

Appendix G

Client Gift Card Receipt

Health District _____ Date _____

This form serves as confirmation that the client has received the gift card(s) listed below. Upon receipt/distribution, both the Nurse Case Manager/designee and the client are required to sign.

Card Number(s)	Card Amount
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$

Client Name Signature

Nurse Case Manager/Designee Name Signature

Confidentiality Notice

This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy this information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken related to the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.